114.2 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

6.01: General Provisions

(1) Scope and Purpose. 114.2 CMR 6.00 governs the payments effective September 1, 2006 for services rendered to Publicly Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility.

(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G.

(3) Disclaimer of Authorization of Services. 114.2 CMR 6.00 is not authorization for or approval of the substantive services, or lengths of time, for which rates are determined pursuant to 114.2 CMR 6.00. Governmental units that purchase services from eligible providers are responsible for the definition, authorization, and approval of services and lengths of time provided to publicly-aided individuals. Information concerning substantive program requirements must be obtained from purchasing governmental units.

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units that may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Building. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures made a

permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Capital Costs. Capital Costs include Building Depreciation, Financing Contribution, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of six categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

CMS. The federal Centers for Medicare and Medicaid Services.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g. drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs.

Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

Generally Available Employee Benefits. Employee benefits that are nondiscriminatory and available to all full-time employees.

Hospital-Based Nursing Facility. A separate Nursing Facility Unit or Units located in a hospital building licensed for both hospital and Nursing Facility services in which the Nursing Facility licensed beds are less than a majority of the facility's total licensed beds and the Nursing Facility patient days are less than a majority of the facility's total patient days. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was

before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity, or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, et seq.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility that increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the MassHealth Agency.

Massachusetts Corporate Excise Tax. Those taxes that have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) necessary to obtain long-term financing through a mortgage, bond or other long-term debt instrument.

New Facility. Effective September 1, 2004, a New Facility is defined as a facility that opens on or after January 1, 2002. A Replacement Facility is not a New Facility.

Nursing Costs. Nursing costs include the Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, and the Workers

Compensation expense, Payroll Tax expense, and Fringe Benefits, including Pension Expense, associated with those salaries.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, s.71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Other Fixed Costs. Other Fixed Costs include Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment, the Non-Income portion of the Massachusetts Corporate Excise tax, Building Insurance, and Rental of Equipment located at the facility.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the MassHealth Agency. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Private Nursing Facility. A Nursing Facility that formerly served only non-Medicaid residents and does not have a provider agreement with the MassHealth Agency to provide services to public Residents.

Provider. A Nursing Facility providing care to Publicly Aided Residents or Industrial Accident Residents.

Prudent Buyer Concept. The assumption that a purchase price that exceeds the market price for a supply or service is an unreasonable cost.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Related Party. An individual or organization associated or affiliated with, or that has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility licensed prior to January 1, 2002 that replaces its entire building with a newly-constructed facility pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6). A facility that renovates a building previously licensed as a nursing facility is not a Replacement Facility.

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the HCF-1.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility licensed by the Department to provide residential care.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: Nursing

(1) Nursing Standard Payments. Facilities will be paid at the following Nursing Standard Payments:

Payment Group	Management Minute Range	Standard Payment
H	0 - 30	$13.47
JK	30.1 – 110	$35.93
LM	110.1 – 170	$62.88
NP	170.1 – 225	$90.91
RS	225.1 – 270	$111.66
T	270.1 and above	$132.01

6.04: Other Operating Costs.

For all payment groups, the Other Operating Cost Standard Payment is $64.04.

6.05 Capital

(1) Allowable Basis of Fixed Assets and Capital Cost

(a) Allowable Basis of Fixed Assets.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.
2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council and used for Nursing Facility services. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.
3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure, the allowable amount will be limited to the amount

approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's Allowable Basis.

b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June 30, 1976 and 1993 forward.

c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership, increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(b) Capital Costs. The Division will calculate the Provider's Capital Costs including depreciation, Financing Contribution, and Other Capital Costs as defined below.

1. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets as of December 31, 2000. Depreciation of Buildings, Building Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Building Improvements	20	5%
Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

2. Financing Contribution. The Division will calculate a Financing Contribution by multiplying 7.625% by the Allowable Net Book Value as of December 31, 2000. The Allowable Net Book Value is the allowable basis less all accumulated depreciation calculated for the period through December 31, 2000, except allowed Building depreciation expense that occurred between January 1, 1983 and December 31, 1992.
3. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.
4. Capital Costs. The Division will calculate the Provider's Capital Costs by adding allowable 2000 depreciation and Other Fixed Costs and the Financing Contribution.
5. Capital Cost Per Diem. The Division will calculate the Provider's 2000 Capital Cost per diem by dividing 2000 Capital Costs by the greater of: a) 96% of Constructed Bed Capacity times 365 or b) the Actual Utilization Rate in 2000 times 365.

(2) Capital Payment. The Division will include capital payments listed in 114.2 CMR 6.05(2)(d) for the following facilities:

(a) New Facilities and Licensed Beds that become operational on or after February 1, 1998 and are:

1. New or Replacement Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;
2. New Facilities constructed in Urban Underbedded areas exempt from the Determination of Need process;
3. New beds licensed pursuant to a Determination of Need approved after March 7, 1996; and
4. New beds in twelve-bed expansion projects not associated with an approved Determination of Need project.

(b) Hospital-Based Nursing Facilities; and

(c) Private Nursing Facilities that sign a Provider Agreement with the MassHealth Agency after September 1, 2004.

(d) The capital payment will be as follows:

Date that New Facilities and Licensed Beds Became Operational	**Payment Amount**
Prior to February 1, 1998 (for hospital-based nursing facilities only)	$17.29
February 1, 1998 – December 31, 2000	$17.29
January 1, 2001 – June 30, 2002	$18.24
July 1, 2002 – December 31, 2002	$20.25
January 1, 2003 – August 31, 2004	$20.25
September 1, 2004 – June 30, 2006	$22.56
July 1, 2006 – Forward	$25.82

(3) Capital Payment – Other Facilities. For all other facilities, the Capital Payment is based on the facility's Capital Costs, including allowable depreciation, Financing Contribution, and Other Fixed Costs.

(a) If a facility's capital payment effective August 31, 2004 is less than $17.29, its capital payment will be determined as follows:

Capital Payment Effective August 31, 2004	Capital Payment Effective September 1, 2004 - Present
$4.50	$4.45
$6.25	$6.18
$8.25	$8.15
$10.25	$10.13
$12.25	$12.11
$14.25	$14.08
$16.25	$16.06
$17.29	$17.29

2. If a facility's capital payment effective August 31, 2004 is greater than or equal to $17.29, the facility's revised capital payment will equal its August 31, 2004 capital payment.
3. If a Provider relicensed beds in 2001 that were out of service, its Capital Payment will be the lower of $17.29 or the facility's most recent billing rates for Fixed Costs and Equity or Use and Occupancy.
4. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, and the Provider receives a temporary Capital Payment in accordance with 6.05(4)(b)(3), then the Division will revise the Provider's Capital Payment in accordance with 6.05(4)(b)(4).

(4) Revised Capital Payment for Substantial Capital Expenditure.

(a) General Notification Requirements. All Providers must notify the Division when they open, add new beds, renovate or re-open beds. The notification must contain the Provider's name, address and VPN, date of bed change, type of change and description of project.
(b) Request for Revised Capital Payment. Eligible Providers may request a revised Capital Payment for capital costs associated with the change or renovation of licensed beds.

1. Facilities that may request a revised Capital Payment include:
   a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need;
   b. Replacement Facilities that open on or after September 1, 2005 pursuant to a Determination of Need;
   c. Facilities with Renovations made pursuant to a Determination of Need;
   d. Facilities with twelve bed additions; and
   e. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

2. If a Provider listed in 114.2 CMR 6.05(4)(b)1 requests a revised Capital Payment to reflect a change in beds, it must submit the following:
   a. a description of the project;
   b. a copy of the construction contract;
   c. copies of invoices and cancelled checks for construction costs;
   d. a copy of the Department's licensure notification associated with the new beds; and

e. a copy of the mortgage.

The Division may request further information it determines necessary to calculate a revised Capital Payment.

3. The Division will certify a temporary Capital Payment of $22.56 upon receipt of the notification of the change in beds, rate adjustment request, and required supporting documentation.

4. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, in order to calculate the final revised Capital Payment the Division will determine the amount of new allowable assets and apply the Financing Factor in 114.2 CMR 6.05(1)(b)2.

(c) Revised Capital Payment.

1. For the Providers specified in 114.2 CMR 6.05(2)(a), the Division will certify a Capital Payment of $22.56.

2. For the following facilities, the final revised Capital Payment will be the greater of 90% of the amount calculated under 114.2 CMR 6.05(4)(b)4 or $22.56:

a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need approved on or before March 7, 1996;

b. Replacement Facilities that open on or after July 1, 2002 pursuant to a Determination of Need approved on or before March 7, 1996;

c. Facilities with twelve bed additions associated with a Determination of Need approved on or before March 7, 1996; and

d. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

3. For the following facilities, the revised Capital Payment will be the lower of the amount calculated under 114.2 CMR 6.05(4)(b)4 or $22.56:

a. facilities that renovate pursuant to a Determination of Need approved after March 7, 1996**;**

b. facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, the revised Capital Payment will be determined under 114.2 CMR 6.05(3)(c)1; and

c. facilities with a twelve-bed addition and simultaneously renovate pursuant to a Determination of Need approved after March 7, 1996.

4. For Facilities with Renovations made pursuant to a Determination of Need approved before March 7, 1996, if the revised amount calculated under 114.2 CMR 6.05(4)(b)4 is greater than $22.56, the Capital Payment will be 90% of the amount calculated under 114.2 CMR 6.05(4)(b)4. If the calculated amount is lower than $22.56, the Capital Payment will be the amount calculated under 114.2 CMR 6.05(4)(b)4.

(d) Effective Date. The effective date of the revised Capital Payment will be the date upon which the Provider submits the notification and all information and documentation required in 114.2 CMR 6.05(4)(b)2.

(e) Weighted Capital Payment. If a provider receives a revised capital payment for new beds and also has beds for which payment is determined under 114.2 CMR 6.05(3)(a), the Division will calculate a weighted capital payment. The provider's capital payment will be determined in accordance with the schedule in 114.2 CMR 6.05(3)(a). The payment rate will be the next highest payment rate from the weighted rate as calculated by the Division.

6.06 Other Payment Provisions

(1) Add-on for Direct Care Workers. Pursuant to the provisions of Section 43 of Chapter 300 of the Acts of 2002, the Division will include an add-on for direct care workers. Direct care workers are defined as registered nurses, licensed practical nurses, certified nurses assistants and the Director of Nurses, including staff working at the facility who are employed by nursing pools registered with the Department. This add-on is for the purpose of increasing wages and benefits of direct care staff; increasing the facility's staff-to-patient ratio; or demonstrably improving the facility's recruitment and retention of nursing staff to provide quality care.

(a) Calculation of the Add-on.

1. For each Provider, the Division will determine the total reported 2000 RN, LPN, DON, and CNA salaries.
    a. If the Division used a short year 2000 cost report to calculate the Provider's 2000 rate, the Division will annualize the reported RN, LPN, CNA, and DON salaries for that Provider.
    b. If a Provider opened after 2000, the Division will calculate the add-on using 2000 median reported RN, LPN, CNA, and DON salaries.
    c. If a Provider's number of licensed beds in the rate period decrease significantly from the 2000 cost report, the Division will adjust the 2000 reported RN, LPN, CNA and DON salaries proportionally to the decrease in the number of beds.
2. The Division will multiply the Provider's 2000 RN, LPN, CNA and DON salaries by the Provider's 2002 Medicaid Utilization as reported in the 2002 Cost Report. Medicaid Utilization is Total Reported Medicaid Days, including MA Commission for the Blind days, divided by Total Reported Patient Days.
3. The Division will total the amounts determined for each Provider.
4. The Division will divide each Provider's amount by the total amount for all Providers.
5. The Division will multiply the resulting percentage by $50 million.
6. The Division will divide the amount calculated above by the product of:
    a. current licensed bed capacity for the rate period , times 365, times
    b. reported 2002 Actual Utilization, times
    c. reported 2002 Medicaid Utilization, times
    d. 1.0897, to adjust 2002 Medicaid Utilization to the projected rate period level.
7. This amount will be included as an add-on to each Provider's rate.

(b) Direct Care Add-on Recovery. There are four permissible uses of direct care add-on revenue. For the recovery calculations, the base period is January 1, 2003 through May 31, 2003. The rate period is July 1, 2006 through June 30, 2007.

1. Nursing costs in excess of the median. The Division will:
    a. Calculate the facility's rate period cost per management minute using the same methodology as is used to calculate the standard payment amount.
    b. Calculate the "per minute difference" between the facility's rate period cost per management minute and the "target amount", which is 2002 median cost per minute inflated (including $8 'T' add-on), weighted by statewide casemix proportions. The Division will publish the target amount in an Administrative Bulletin.
    c. If the facility's cost per management minute is higher than the standard cost per management minute, the per minute difference * facility average rate period minutes * rate period total patient days = allowable funds counted toward compliance.

2. Increasing wages and benefits. Providers may use the add-on revenue to increase base hourly wages, payroll taxes, and benefits for direct care workers employed by the facility. Such wage increases must be over and above any previously collectively bargained for wage increases paid in the rate period. Such revenue may be spent on overtime, bonuses, benefits, and retroactive wage increases. The Division will compare the facility's average hourly wage rate in the rate period to the average hourly wage rate in the base period. The amount that may be counted toward compliance equals this wage increase times total rate period direct worker hours.

3. Increasing staff-to-patient ratio. Facilities may spend revenue on additional nursing hours, as measured by an increase in the staff-to-patient ratio. The Division will calculate the ratio of hours to patient days for the base period (base period ratio). The base period ratio times the days in the rate period equals the "expected hours". If actual hours exceed expected hours, the difference in hours times the direct cost per hour in the base period equals the allowable amount counted toward compliance. The Division will increase the base period expense by $3.72 times Medicaid days for the base period times 3/5.

4. Improving facility's recruitment and retention. The facility must document

(a) improvement in recruitment and retention, as measured by improved staff turnover rates or lower staff vacancy rates; and

(b) the dollar amounts associated with specific programs used (net of savings initiatives) including bonuses, training and increased recruitment efforts.

(c) If the total amount of Direct Care add-on revenue exceeds the amounts counted toward compliance, 150% of the difference will be recovered by the MassHealth Agency. Final compliance is the higher of the following:

1. the sum of the compliance amounts determined in 114.2 CMR 6.06(2)(b)1 and 114.2 CMR 6.06(2)(b)4, or

2. the sum of the compliance amounts determined in 114.2 CMR 6.06(2)(b)2 and 114.2 CMR 6.06(2)(b)3.

The Division and/or the MassHealth Agency may conduct audits to verify amounts reported by the facility related to the use of direct care add-on revenue.

(2) Retroactive Adjustments. The Division may retroactively adjust payments in the following situations:

(a) Mechanical Errors. The Division may adjust payments if it learns that there is a material error in the rate calculations.

(b) Errors in the Cost Reports. The Division may adjust payments if it learns that the Provider has made a material error in the cost report.

(3) Ancillary Costs. Unless a Provider participates in the Ancillary Pilot Program with the MassHealth Agency, or a Provider's payments include Ancillary Services pursuant to the regulations or written policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(4) Residential Care Beds. Effective September 1, 2006, payments for Nursing and Other Operating costs for Residential Care Beds in a dually-licensed facility will equal a standard payment of $66.82.

(5) Reopened Beds Out of Service. Providers with licensed beds that were out of service prior to September 1, 2006 that reopen September 1, 2006 or later will receive the lower of the Standard Payments or the most recent prior payments inflated to the September 1, 2006 through June 30, 2007 period for Nursing and Other Operating Costs.

(6) Pediatric Nursing Homes. Payments to facilities licensed to provide pediatric nursing facility services will be determined using 2002 Allowable Reported Costs for Nursing and Other Operating Costs, excluding Administration and General Costs, adjusted by a Cost Adjustment Factor of 9.63% percent. Administration and General Costs will be based on 2002 costs, subject to a cap of $14.85. Nursing costs will be reduced by CNA add-on revenue received in 2002. A pediatric nursing facility may apply to the Division for a payment adjustment for the otherwise unrecognized medical costs of residents over the age of 22 who were previously enrolled in the facility's Chapter 766 program. The Division will calculate an adjustment to include the reasonable costs for these services subject to approval by the MassHealth Agency.

(7) Payments for Innovative and Special Programs. The Division will include an allowance for costs and expenses to establish and maintain an innovative program for providing care to Publicly-Aided Residents if:

(a) The Provider has received prior written approval from the Executive Office of Elder Affairs to establish and maintain a program; or

(b) The Provider participates in a special program pursuant to a contract with the MassHealth Agency under which it has agreed to accept residents designated by that agency.

(8) Receiverships. The Division may adjust the rate of a receiver appointed under M.G.L. c. 111, s. 72N solely to reflect the reasonable costs, as determined by the Division and the MassHealth Agency, associated with the court-approved closure of the facility.

(9) Other Payments.

(a) Effective October 1, 2002, there will be an add-on for the Medicaid portion of the nursing facility user fee assessment. The add-on will be equal to the user fee assessed pursuant to 114.5 CMR 12.00. The Division may recertify a prior period rate to exclude this add-on if the Facility fails to incur the cost of the nursing facility user fee assessment within 120 days of the assessment due date.

(b)Eligible facilities will receive an add-on to reflect the difference between the standard payment amounts and actual base year nursing spending. To be eligible for such payment, the Department must certify to the Division that over 75% of the facility's residents have a primary diagnosis of multiple sclerosis.

(c) Facilities with kosher kitchen and food service operations may receive an add-on of up to $5 per day to reflect the additional costs of these operations.

(a) Eligibility. To be eligible for this add-on, the facility must meet the following criteria:

1. maintain a fully kosher kitchen and food service operation that is, at least annually, rabbinically approved or certified; and in accordance with all applicable requirements of law related to Kosher food and food products, including but not limited to, M.G.L. c. 94, §156;

2. provide to the Division a written certification from a certifying authority, including the complete name, address and phone number of the certifying authority, that the applicant's nursing facility maintains a fully kosher kitchen and food service operation in accordance with Jewish religious standards. For purpose of this paragraph, the phrase "certifying authority" shall mean a recognized Kosher certifying organization or rabbi who has received Orthodox rabbinical ordination and is educated in matters of Orthodox Jewish law;

3. provide a written certification from the Administrator of the nursing facility that the percentage of the nursing facility's residents requesting kosher foods or products prepared in accordance with Jewish religious dietary requirements is at least fifty percent (50%); and

4. upon request, provide the Division with documentation of expenses related to the provision of kosher food services, including but not limited to, invoices and payroll records.

(b) Payment Amounts.

1. To determine the add-on amount, the Division will determine the statewide median dietary expense per day for all facilities. The difference between the eligible facility's dietary expense per day and the statewide median will be the amount of the add-on, not to exceed $5 per day. In calculating the per day amount, the Division will include allowable expenses for dietary and dietician salaries, payroll taxes and related benefits, food, dietary purchased service expense, dietician purchased service expense, and dietary supplies and expenses. The days used in the denominator of the calculation will be the higher of the facility's actual days or 96% of available bed days.

2. The Division will compare the sum of the add-on amounts multiplied by each facility's projected annual rate period Medicaid days to the state appropriation. In the event that the sum exceeds the state appropriation, each facility's add-on shall be proportionally adjusted.

(d) In the event that any additional funds become available in the Health Care Quality Improvement Trust Fund due to decreased Medicaid utilization, pursuant to Chapter 45 of the Acts of 2005, the Division will apply the surplus towards a Large Medicaid Provider Supplemental Payment. A nursing facility will be eligible for the supplement if it meets all of the following criteria:

1. The facility had at least 188 licensed beds in 2002.

2. The facility had Medicaid occupancy of 70% or higher in 2002. For purposes of this section, Medicaid occupancy is defined as annual Medicaid days divided by total patient days as reported in the 2002 HCF-1.

3. The facility has a score of at least 123 on the Department's Nursing Facility Survey Performance Tool as received by the Division on March 25, 2005.

The Division will calculate the amount of the supplemental payment received by each eligible facility as follows:

1. The Division will divide the number of reported 2002 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities.

2. The Division will multiply the resulting percentage by the amount of the surplus.

3. The Division will divide the amount calculated above by the product of:

a. current licensed bed capacity for the rate period , times 365, times

b. reported 2002 Actual Utilization, times

c. reported 2002 Medicaid Utilization.

4. This amount will be included as an add-on to each Provider's rate.

This supplemental payment will be effective from September 1, 2006 through August 31, 2007.

e) In the event that the Division determines that capital payments fall short of the requirement set forth in St. 2005, c. 45, § (4) or St. 2006, c. 157, § (a)(4), the Division will make a supplemental payment to qualifying facilities.

1. Determination of Available Funding. The Division will determine whether there is surplus funding in the Health Quality Improvement Trust Fund available to fund capital payments due to a variance between projected and actual Medicaid utilization at the end of each fiscal year for payment in the next fiscal year.

2. Eligible Facilities. The Division will allocate available funding to publicly-operated nursing facilities owned and operated by a town, city, or state government entity in Massachusetts.

3. Calculation of Supplemental Payment. The payments will be allocated as follows:

a. The Division will divide the number of reported 2002 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities.
b. The Division will multiply the resulting percentage by the sum of total supplemental payments.
c. The Division will divide the amount calculated above by the product of:
1. current licensed bed capacity for the rate period , times 365, times
2. reported 2002 Actual Utilization, times
3. reported 2002 Medicaid Utilization.
d. This amount will be included as an add-on to each Provider's rate.

4. Effective Dates. This supplemental payment will be effective from September 1, 2006 through August 31, 2007.

(10) Allowance for Department of Mental Retardation (DMR) Requirements. Eligible nursing facilities will receive a one-time allowance to establish and maintain clinical and administrative procedures in a manner that complements DMR interdisciplinary service planning activities under the "Active Treatment Policy" for nursing facility residents with mental retardation and developmental disabilities, which was issued by the Executive Office of Health and Human Services in December 2002.

(a) Eligibility. Eligible nursing facilities are identified by the Department of Mental Retardation as nursing facility providers of care to nursing facility residents with mental retardation or development disabilities as of July 25, 2003.

(b) Calculation of Allowance. For each eligible nursing facility identified by DMR, the number of residents identified by DMR as having mental retardation or developmental disabilities and communicated to the Division as of July 24, 2006, times $2.72, times 365 days, will equal the total allowance amount. To calculate a per diem amount to be included in the payment rates, the Division will divide the allowance amount calculated above by the product of items 1 through 3 below:
1. current licensed bed capacity for the rate period , times 365,
2. reported 2002 Actual Utilization percentage, times
3. reported 2002 Medicaid Utilization percentage.

(c) If the DMR notifies the Division that a facility has failed to comply with its requirements or failed to cooperate with the planning activities under the Active Treatment Policy, the Division may deem the facility to be ineligible for this adjustment and rescind this allowance for a provider.

(11) Annualization Adjustment. Nursing facilities will receive an additional, one-time adjustment to annualize all rate increases with a September 1, 2006 effective date. This adjustment will expire effective July 1, 2007. Included in this adjustment is a negative adjustment to correct for annualization adjustment payments made to facilities during July and August of 2006. The Division may recertify the rates effective July 1, 2007 to eliminate the adjustment in rates effective on or after July 1, 2007. The adjustment will be comprised of the following:

Nursing Standard H	$0.03
Nursing Standard JK	$0.09
Nursing Standard LM	$0.16
Nursing Standard NP	$0.23
Nursing Standard RS	$0.28
Nursing Standard T	$0.31
Other Operating Standard	$0.10
Residential Care Beds	$-0.06

The following annualization adjustments will be calculated by multiplying the difference between the 2006 and 2007 add-ons by 20%, and subtracting 20% of the annualization adjustment effective during SFY 2006 to correct for annualization adjustment payments made during July and August 2006.

Direct Care Add-On
Allowance for DMR Requirements

(12) Leave of Absences. For the purposes of a medical leave of absence for Medicaid eligible residents, a facility must ensure that the bed in the facility occupied by said resident before the hospitalization will be available upon the return of said resident from an inpatient acute hospital stay for a period of not less than ten (10) days. If a facility fails to hold this bed open, it will be ineligible to receive direct care payments pursuant to 114.2 CMR 6.06(1), payments pursuant to 114.2 CMR 6.06(9), or allowances for DMR requirements pursuant to 114.2 CMR 6.06(10). The Division may make further adjustment to the facility's rate to comply with the provisions of Chapter 42 of the Acts of 2003.

6.07 Reporting Requirements

(1) Required Cost Reports

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses. If a provider has closed on or before November 30, the provider is not required to file an HCF-1 report.

(b) Realty Company Cost Report. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.

(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.

(d) Financial Statements. If a Provider or its parent organization is required or elects to obtain independent audited financial statements for purposes other than 114.2 CMR 6.00, the provider must file a complete copy of its audited Financial Statements that most closely correspond to the provider's Nursing Facility Cost Report fiscal period. If the provider or its parent organization does not obtain audited Financial Statements but is required or elects to obtain reviewed or compiled Financial Statements for purposes other than 114.2 CMR 6.00, the provider must file a complete copy of its Financial Statements that most closely correspond to the Nursing Facility Cost Report fiscal period. Financial Statements must accompany the provider's Nursing Facility Cost Report filing. Nothing in this section shall be construed as an additional requirement that nursing homes complete audited, reviewed, or compiled Financial Statements solely to comply with the Division's reporting requirements.

(e) Collective Bargaining Agreements for CNAs. If a Provider has a collective bargaining agreement in effect with any or all CNAs employed by the facility between the period April 1, 2000 and December 31, 2002, it must provide to the Division copies of any collective bargaining contracts and the applicable CNA wage schedules that are or were in effect during that period. Facilities will be required to identify the total wage and payroll tax amounts that are attributable to the collective bargaining agreements.

(2) General Cost Reporting Requirements

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger that clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions that the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:

a. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;

b. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, that are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and

c. Expenses related to policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the Provider.

d. providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.

3. Expenses that Generate Income. Providers must identify the expense accounts that generate income.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets that are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment , accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.

6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.

7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.

8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.

(f) Special Cost Reporting Requirements.

1. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.

a. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.

b. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.

c. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The

Provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

a. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.

b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:

1. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, that clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first Notification of Change in Beds.

2. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment , the Division will allocate fixed Equipment on a square footage basis.

c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The Division will allocate capital expenditures that relate to the total plant on a square footage basis.

d. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics used in preparing the Nursing Provider Cost Report.

(3) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;

(b) The cost adheres to the Prudent Buyer Concept;

(c) Payments to related parties: Expenses otherwise allowable shall not be included for purposes of determining rates under 114.2 CMR 6.00 where such expenses are paid to a Related Party unless the provider identifies any such Related party and expenses attributable to it in the Reports submitted under 114.2 CMR 6.00 and demonstrates that such expenses do not exceed the lower of the cost to the Related Party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the provider or the Related Party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

(d) Employee Benefits: Only the provider's contribution of Generally Available Employee Benefits shall be deemed an allowable cost. Providers may vary Generally Available Employee Benefits by groups of employees at the option of the employer. To qualify as a Generally Available Employee Benefit, the provider must establish and maintain evidence

of its nondiscriminatory nature. Generally Available Employee Benefits shall include but are not limited to group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. Bonuses related to profit, private occupancy, or directly or indirectly to rates of reimbursement shall not be included for calculation of prospective rates. Benefits which are related to salaries shall be limited to allowable salaries. Benefits, including pensions, related to non-administrative and non-nursing personnel will be part of the other operating cost center. Benefits that are related to the Director of Nurses, including pensions and education, shall be part of the Nursing Cost Center. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken, provided that these benefits are both stated in the written policy and are the actual practice of the provider and that such benefits are guaranteed to the employee even upon death or termination of employment. Such expenses may be recorded and claimed for reimbursement purposes only as of the date that a legal liability has been established.

(e) The cost must be for goods or services actually provided in the nursing facility; and

(f) The cost must be reasonable; and

(g) The cost must actually be paid by the Provider. Costs not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs discharged in bankruptcy; costs forgiven; costs converted to a promissory note; and accruals of self-insured costs based on actuarial estimates;

(h) A provider may not report the following costs as related to the care of Massachusetts publicly-aided Residents:

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;
2 Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;
3. Expenses not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;
4. Compensation and fringe benefits of residents on a Provider's payroll;
5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;
6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies not registered with the Department under regulation 105 CMR 157.000 or paid for at rates greater than the rates established by the Division pursuant to 114.3 CMR 45.00;
8. Any expense or amortization of a capitalized cost that relates to costs or expenses incurred prior to the opening of the facility;
9. All legal expenses, including those accounting expenses and filing fees associated with any appeal process;
10. Prescribed legend drugs for individual patients;
11. Recovery of expense items, that is, expenses that are reduced or eliminated by applicable income including but not limited to, rental of quarters to employees and others, income from meals sold to persons other than residents, telephone income, vending machine income and medical records income. Vending machine income shall be recovered against Other Operating Costs. Other recoverable income shall be recovered against an account in the appropriate cost group category, such as Administrative and General Costs, Other Operating Costs, Nursing Costs, and

Capital Costs. The cost associated with laundry income which is generated from special services rendered to private patients shall be identified and eliminated from claims for reimbursement. Special services are those services not rendered to all patients (e.g., dry cleaning, etc.). In the event that the cost of special services cannot be determined, laundry income shall be recovered against laundry expense.

12. Costs of ancillary services required by 114.2 CMR 6.00 or by a governmental unit to be billed on a direct basis to the purchasing government unit;
13. Accrued expenses which remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, shall not be included in the prospective rates. When the Division receives satisfactory evidence of payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable prospective rates.

(4) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of March 1 of the following calendar year. If March 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
2. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

(b) Extension of Filing Date. The Division may grant a request for an extension of the filing due date for a maximum of 30 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances that prevent the Provider from meeting the deadline; and
3. file the request with the Health Data Policy Group at the Division of Health Care Finance and Policy no later than 30 calendar days before the due date.

(c) Administrative Bulletin. The Division may modify the Filing Deadlines by issuing an administrative bulletin 30 days prior to any proposed change.

(5) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information that the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by March 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(6) Audits. The Division and the MassHealth Agency may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(7) Penalties. If a Provider does not file the required Cost Reports by the due date, the Division may reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

6.08 Special Provisions

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division files the rate with the State Secretary. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

(3) Administrative Bulletins. The Division may issue administrative bulletins to clarify provisions of 114.2 CMR 6.00 which shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 6.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 6.00: M.G.L. c. 118G.